MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 19, 2001
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Blood safety requirements: impact on hospital costs and payment options
Tim Greene

MR. HACKBARTH: Next on the agenda is blood safety requirements for the December 2001 report. Tim?

MR. GREENE: Good morning. I'll be discussing the report mandated by BIPA under the [inaudible]

Hospital blood related costs increased more rapidly than overall operating costs over the last 15 years, due mostly to newly imposed safety requirements and the costs of technologies required to meet those requirements. In addition, blood related costs probably increased significantly in fiscal year 2001 that just ended reflecting major price increases for products. Finally, three new blood safety technologies which I'll be discussing in a minute will probably lead to future cost increases.

Hospital payments under the inpatient PPS are, as you know, adjusted over time to reflect changes in hospital costs. These updates are set mainly by the changes in the marketbasket for hospital inputs. The current marketbasket does not include a component that explicitly and separately reflects the costs of blood products. This raises a question of the proper treatment of blood and blood-related costs under the hospital inpatient PPS.

BIPA requires that MedPAC conduct a study on any increased hospital costs from fiscal year 1984 through fiscal year 1999 attributable to new blood safety requirements and implementation of new related technologies. It requires that we examine whether inpatient PPS adequately recognizes costs and it requires that we estimate, to the extent feasible, changes in costs in the future from 2001 through 2010. It also requires that you consider possible changes to the inpatient PPS to deal with these future expected cost increases.

This morning I'll be presenting a summary of recommendation options to start with, then a brief overview of our report. Finally, I'll be returning to a more detailed description and discussion of the recommendation options and other alternatives.

Just by way of overview, there are four options for action by CMS or the Congress that we consider. I will note them now and return to them in more detail. First, BIPA requires that when CMS next revises the hospital marketbasket, it give special attention to the adequacy of payment for blood and blood products.

I'll be discussing two alternative modifications to the marketbasket that we believe CMS could consider to meet this mandate. Second, Congress could increase the update by an amount to take account of costs of blood technologies on overall hospital costs. Although I realize you're considering changes in your update approach that would suggest that you would not support such an alternative, we did include it as an alternative

to at least be considered.

Third, another alternative would be to increase the update every year by a fixed amount, a set number repeatedly every year, as a way of dealing with these costs. This was considered by Congress last year and not adopted. But because it's been a live political possibility, we included it as something to consider.

Finally, CMS can address these costs using the new technology pass-through provisions of BIPA. In that case, it would assign a new technology pass-through payment for these presumed technology costs.

The MedPAC report presents a discussion of the development of regulations and private sector standards dealing with the safety of the blood supply. MedPAC staff, supported by Project HOPE under contract, identified relevant technologies and use during the historical period and anticipated in the future.

Project HOPE identified several major issues for the future pertaining to blood testing, methods for processing blood to enhance safety, and policies to screen donors to avoid tainted blood. It also studied three specific technologies, nucleic acid amplification testing, a leuko reduction system for removing white blood cells when blood is processed for use, and a newly developed technology called pathogen inactivation which is a way of eliminating infections from blood whether they've been identified by testing or not. They all promised to be important and to be sources of future cost increases.

We discussed them at greater length in the report and in an appendix report presenting in detail Project HOPE's findings.

I'll be now turning to an overview of our empirical findings. We examined data on prices of blood products. We identified a measure for overall blood price, in this case the producer price index for blood and derivatives for human use. And secondly, we developed a measure of prices of blood focusing on the products used by hospitals, which we described as a hospital blood products measure.

The first, we determined grew at an annual rate of less than the growth in the marketbasket over the historical period 1984 to 1999, while the second -- our measure of hospital blood price -- increased at a more rapid rate than the marketbasket. However, these blood price indexes are very erratic over the longer period, over the full period. And more important, these alternative indexes give a very different picture of what's going on, both over the long period and individual subperiods.

We concluded from that that we really can't reach an unambiguous judgment about the effects of price changes here on hospital costs. So we turned to Medicare hospital cost data as an alternative.

We examined two measures of Medicare blood related costs. The first is based on cost report information on facility blood related costs from the relevant cost centers for all PPS cases. The second is based on hospital bill data on these costs solely for cases of patients hospitalized who actually used blood. Both, however, give very similar results over the 1986 to 1999 period. We're choosing that slightly shorter period for data reasons.

Both grew somewhat faster than overall costs per discharge and per user respectively. However, the difference in the growth of costs between the blood cost measure and the overall cost measure is very small, less than half a percentage point per year. And as we knew, the share of blood costs in total hospital costs is also quite small. As a result, there's very little impact of these price divergences on total hospital costs for the period.

Now I turn to the policy context, which is the hospital payment system. Medicare inpatient PPS pays hospitals a fixed amount per discharge for all services provided by the hospital. Payment is made for an all-inclusive bundle of services, not for actual inputs used. In particular, it doesn't depend on whether blood or any other specific resource is used to treat any specific case.

This is important in trying to keep perspective on consideration of cost increases pertaining to just one input, whether it's important or unimportant.

Over the 1986 to 1999 period we know that hospitals were able to offset the prices, increase the prices of some inputs by reducing use of other inputs and, in particular, by shifting a good deal of care out of the inpatient setting to post-acute setting, and reducing the number of days at the end of a stay, and reducing the resources used to treat any specific PPS case. We've discussed that many times previously and in several MedPAC reports.

As a result, total operating payments per discharge over the 1986 to 1999 period increased more rapidly than PPS operating costs per discharge, leading to positive margins over a good deal of that period. They increased at approximately the rate of blood costs. So even if we are concerned with comparing payments to the cost of a single input, payment growth approximately matches this slightly higher than overall blood cost growth.

Looking forward, blood related costs, as I indicated, probably rose significantly in fiscal year 2001 as a result of product increases in July, is where a 35 percent price increase by American Red Cross, which is the dominant supplier of blood to the nation's hospitals. Red Cross says 35 percent, American Hospital Association reports that some of its members are reporting 100 percent price increases. So this could be significant in this one year.

In addition, the three technologies which I discussed earlier are likely to lead to continuing cost increases as they diffuse in the blood-banking system and depending on the costs that are actually realized over the next several years.

The question for CMS and for the Commission then is how to prepare the payment system to deal with these current and anticipated cost increases.

We conducted a careful review of the treatment of blood-related costs in the hospital marketbasket. We identified two alternative ways of modifying the marketbasket to reflect these costs. Marketbasket consists of 22 cost categories or components. Before fiscal year 1997 it included a separate explicit measure of the costs of blood to inpatient hospital

designed to reflect the relative importance of that input.

The first alternative would be for CMS to reverse the decision it took in 1997 and reintroduce a separate cost component for blood products into the marketbasket. This alternative would essentially be to return to the pre-1997 marketbasket design.

The second alternative would be for CMS to create a new component combining blood costs with other clinically related costs. It would then identify an appropriate price proxy to use with this measure, estimated weight for the measure from hospital cost data and incorporate it in the marketbasket. We present specific information and a possible price proxy in the briefing material, but I'm not going to stop to go into them at this point.

We do think that both options would be both appropriate for dealing with input price changes and would be preferable to the current combination of cost categories and price proxies.

Those are the options.

DR. ROWE: What are the practical differences between these two?

MR. GREENE: The first explicitly breaks out this very small category.

DR. ROWE: I understand what they do. Is there a preferred pathway here?

MR. GREENE: I don't have strong preferences between the two. I think they're both attractive in their own way. The second, of course, merges this category in a larger one and, in that sense, is less responsive to price change in that particular component. On the other hand, arguably it's more appropriate because you may not want to base a change on such a small --

DR. ROWE: Do the hospitals have a preference?

MR. GREENE: Not that I know.

MR. MULLER: I have a question. Obviously, when something is half a percent of the overall, one doesn't worry that much. But when it starts accelerating at 35 percent, compounding if that goes on for a while, it can get to be a number that has a big effect on costs. If, in fact, it kept going up 35 percent for a longer period of time, everybody would have to take steps to accommodate and make substitutions, et cetera.

But the question I have therefore is what's the precedent that we have when something starts accelerating like that? Do we wait to see whether it goes on for an extended period of time? Do we anticipate that it might? Again, if it's .6 of a percent, I can understand people saying don't worry about that one. But you could also see this accelerating up to two or three pretty fast if this kind of slope continues.

MR. GREENE: The marketbasket is revised fairly regularly, every four or five years. I don't think they do ad hoc revisions between those periods in response to energy price increases. So the short answer is no, I don't think that they make quick adaptations.

MR. HACKBARTH: Tim, is there any rule of thumb about when they combine components, as opposed to identify something as a separate item in the calculation? Since that seems to be the

distinction between those two options.

MR. GREENE: I don't know the standard rules.

MR. HACKBARTH: How big does it have to be before it becomes separate, as opposed to combined with other things?

DR. NEWHOUSE: I would think it would turn on whether we think we have a good price index for that particular component. And if we do, it probably doesn't much matter but it's cleaner to keep it separate I would think.

MR. GREENE: Just a point I made in the briefing material that's led to a lot of discontent here is that when the blood price component was eliminated blood cost was combined with chemicals and they're indexed not by an industrial chemicals index, which seems very far removed from the -- it's arguably appropriate, but when you look more carefully, it really is not an appropriate measure.

DR. NEWHOUSE: So why did they do this, do we know?

MR. GREENE: Partly because at the time the decision was made the blood price was actually declining. Certainly it was flat and it was actually declining. The weight is very small and if, in fact, the decline had continued it would have been even smaller. I don't know the details but I'm sure it was partly a pragmatic judgment. This is the nearest thing we can put it in with. When we looked at it it didn't seem like an appropriate combination.

DR. REISCHAUER: I think the concern will continue if we bundle together a group of things simply because this is coming about because of extraordinary rise in the price of blood products and whatever price index is chosen to be appropriate will undoubtedly be lower than the increase in blood. So I would opt for the first of the two.

DR. NEWHOUSE: And here we have, a PPI for blood seemed like a reasonable index to use for this. I'd opt for the first, too.

MR. GREENE: We were careful in our proposal to include, as an alternative proxy, one that is a larger, higher level index that would at least arguably reflect the price changes of blood within it. It's different than industrial chemicals in that sense.

DR. LOOP: I think this is a very unique price change and you've captured a lot of the history but the real effect is in 2001 when it does go up 35 percent. This should be treated as an additive cost. It' snot a revenue issue.

It seems to me that this is sort of new technology and it should be treated as a pass-through.

MR. GREENE: That's another alternative.

DR. LOOP: It's such an unusual change.

MR. HACKBARTH: Tim, why don't you proceed through your discussions, since that is one of the other options and then we can get to the full discussion.

MR. GREENE: Red Cross describes this 35 percent change as a catch-up for a 20-some percent change in cost. So I don't think there's the expectation that this going to continue year after year.

DR. LOOP: I think half of it is due to catch-up and the other half is due to new safety standards, namely universal leuko

reduction.

MR. GREENE: Turning to the next point, which is Floyd's point exactly, we are considering other alternatives to deal with a change like this. One would be, as we discussed yesterday, one traditional approach that MedPAC has taken is to provide a specific single year add-on to reflect the costs of technological change in the update recommendation. The proposals yesterday that you were discussing would move away from that, but I was still considering this as a possibility.

However, the particular case that we're considering here has special reasons to have reservations about this approach. Adjustments such as the technological change adjustment are typically used for technologies that are actually used by hospitals in the inpatient setting. The safety technology we're talking about here are ones that are used by blood banks in producing blood for sale to hospitals as inputs. A small number of hospitals collect donations and produce their own blood, so we're basically talking about these as things that are used by suppliers to produce products that are then sold to hospitals. In that sense, it's very different from technologies that we traditionally deal with through the update mechanism.

Increases in input prices, such as we see here or anticipate here, are generally reflected through the marketbasket rather than through a fixed add-on. So that is a reason to have special reservation about a technology adjustment here, apart from the general considerations yesterday, which is why we considered it as an alternative but didn't fold it in as an option to directly consider.

The second alternative, this is what was considered by Congress in the enactment of BIPA. This would involve a fixed add-on to the marketbasket, in that case a .37 percent add-on was considered by Congress last year, which would continue year after year, the same number added to the update continuously, with a sunset provision in the discussion last year. But that's what we mean when we say a fixed add-on. Here it would be, and in that case it was proposed as an explicit blood cost component. But the concern here is that this would be the precedent for many such add-on proposals. This for blood, that for another technology, that for another use.

Even apart from other questions, the precedent value is a concern.

DR. ROWE: Can I ask a clarifying question, for me at least? What are we adding it on to?

MR. GREENE: Either to the marketbasket value or the update, however you think.

DR. ROWE: Because my concern is that there are many categories of patients, either DRGs or others, in which this problem is concentrated. And there are other entire categories of patients where this is not relevant. For instance, psychiatric patients. A psych hospital should not get an add-on to their marketbasket for the cost of blood products because they don't have a blood bank. They never give a transfusion.

So it would seem to me that we should be a little careful -- we should at least have a principle going forward that has

something to do with that, so that we actually treat the problem, which is the hospitals that do a lot of cardiac surgery, cancer surgery, complex problems, and not psychiatric -- and I'm just making that up. There are other categories, there must be, rehab hospitals, I don't know, where their utilization would be much lower. I just would like to ask that we have some consideration of that as we figure out what to do.

MR. GREENE: One consideration is relative DRG payments are reset every year as part of the DRG weight setting process. Those are calculated reflecting charges two years previously. And to the extent that hospital charges reflect charges for transplants reflect, in part, the higher blood costs, those are going to be reflected down the road in higher weights and higher payments for the affected DRG cases.

DR. NEWHOUSE: What you're really asking for is multiple marketbaskets across hospital types, and it's not clear to me that the gain is worth the candle.

DR. ROWE: No, I'm just asking for fairness.

DR. NEWHOUSE: There are other hospitals that don't use other inputs.

DR. ROWE: If all the commissioners think the psychiatric hospitals should get this, then...

DR. NEWHOUSE: We might put on our agenda for some future time, I think, looking at how different hospitals are in their marketbaskets and whether there should be multiple marketbaskets. But it reaches another level of complexity.

MR. HACKBARTH: We're very near the end of the list of options so why don't you go ahead and do the last one.

MR. GREENE: The last one is the use of a technology pass-through as an alternative way of dealing with these costs. Briefly, this raises the same question I raised with regard to the technology change to the update. The technology pass-through also was designed and enacted to deal with costs of inpatient technologies actually used by hospitals rather than for technologies used by suppliers that might increase the price of input. I'm not even sure if it would be legally appropriate.

MR. MULLER: Now if it's a pass-through, and most of these would be inpatient costs. But for outpatient costs that would just exacerbate that 2.5 percent overrun problem, wouldn't it?

MR. GREENE: Yes.

MR. HACKBARTH: Let's turn to the question of which of these. Can I ask a question to lead that off?

Blood is clearly an input. We have a mechanism for adjusting for changes in input prices; namely the marketbasket. A case may or may not be made about whether the changes in this particular product are being currently accurately reflected through that mechanism. But I don't understand what the argument would be for adopting an entirely separate mechanism, inasmuch as this is an input, and it is a price change. What have I missed?

MR. GREENE: We're not recommending -- the options we present entirely are marketbasket modifications. I was laying out the others for completeness, to acknowledge that we considered them.

MR. HACKBARTH: I guess what I'm asking is, the advocates of

other alternatives, is there any argument that I've missed? I've not heard an argument why we shouldn't use the established mechanism for what is clearly an input.

MR. GREENE: I think there's an understanding -- what advocates have proposed is the fixed add-on proposal, which is based on their estimate of additional costs, which suggests that flat add-on, which would be, in the legislative proposal would be in effect until marketbasket changes were made. That's the logic, marketbasket changes are necessary. Until they're made, we're adding this small amount to updates.

MR. HACKBARTH: In the interest of trying to get to the bottom line as quickly as possible, are there other commissioners who can help me on this? Am I missing something, why this shouldn't be looked at as an input price issue?

DR. REISCHAUER: I think all Tim was saying was, before it can be handled that way, these advocates would like a little money.

MR. GREENE: Yes.

DR. REISCHAUER: But we aren't really speaking to the interim issue here.

MR. GREENE: No, we're not.

DR. ROWE: Can we recommend? Why can't we recommend what I think Tim is recommending, which is that the marketbasket be changed to reflect this, and then an interim payment adjustment be made to compensate for this change until that occurs?

DR. LOOP: You mean an add-on payment adjustment?

DR. ROWE: Yes.

MR. HACKBARTH: Going back to our discussion of yesterday, if we adopt the approach we discussed for looking at the base and then looking at the update, in fact that mechanism should address any shortfall.

DR. REISCHAUER: And do we think this is that serious a problem for the next couple of years? That's the real --

DR. ROWE: My concern is that there are hospitals -- all hospitals aren't equal and there are probably some hospitals where this is a very significant issue. I'm not sure they're going to be aided appropriately by this general change. But nonetheless, I would be in favor of making the change sooner rather than later certainly.

MR. SMITH: But we had a conversation yesterday where we generally agreed that our threshold for that sort of out of the ordinary course of business update ought to be pretty high. I haven't heard, Jack, any evidence or numbers from Tim in the material that suggests this has reached that point. The marketbasket update should take care of that over time, particularly if as Floyd described, we had a one-time spike in a very small base and the update process works.

I think we set a very dangerous precedent if we begin to argue about very small items of cost with very short term spikes, that we're going to do an adjustment every time. It certainly flies in the face of our complexity argument.

DR. NEWHOUSE: David, I agree with your bottom line, but the update won't fix the weight on this issue. What I'd say to Jack though is, there is another way to get at the hospitals doing a

lot of surgery, which is this will feed through to the relative DRG weight and that relative weight will go up.

DR. LOOP: In the meantime, until the index catches up with it, just let me give one statistic. For the Cleveland Clinic, a 30 percent price increase in 2002 will amount to about $2.5 million of uncompensated cost. So that's a lot of money. So I think we need some sort of a short term fix, an update or a pass-through of some kind, because we're in the same boat with a lot of other large hospitals.

MR. HACKBARTH: Help me put that $2.5 million in context, Floyd. Is that $2.5 million for the overall operations of the institution, or is that Medicare specific, and compared to what sort of base are we talking about?

DR. LOOP: It's all patients. It's not just Medicare. If Medicare is 35 percent of it, then it would be 35 percent of that. But actually, that's not true because Medicare patients would use more blood than non-Medicare.

MR. GREENE: David, to respond to your question about magnitudes. Blood in the old marketbasket had 0.06 percent weight, so a 35 percent increase on that would be about 0.2 percentage points that would be included in the update. The question is, is that so small that it doesn't pass the threshold.

MR. MULLER: When you look at [inaudible]. It's not a small number.

MR. SMITH: I don't want to belabor this. I think we're headed toward consensus, but it does strike me that we didn't hear anybody come in here when blood prices were falling and argue that we ought to have a negative adjustment. At 0.2 with a spike, Floyd, that looks like it is not a float but a spike, I think it's a very dangerous precedent to start, at this level, doing add-ons and pass-throughs.

MR. HACKBARTH: If we did an add-on, wouldn't we also logically have to do a take-back when the automatic processes through the recalibration of weights and the index take effect? So we'd also have to get in the business of saying, we've got to do a take-back.

DR. REISCHAUER: Unless it's sunsetted.

MR. GREENE: You could, I suppose. In the update recommendation you would have to be explicit.

DR. ROWE: I need somebody to summarize where we are for me.

MR. HACKBARTH: We're on the draft recommendation page, and it sounds like we've agreed that the issue is an input price issue and it needs to be fixed through the index. Most of the conversation seems to center on whether some interim step is necessary over and above that.

DR. REISCHAUER: But this seems to be a choice that we have before us?

MR. GREENE: These would be a choice, right, between --

DR. REISCHAUER: Actually, although I'm strongly in favor of the first, I would suggest we leave that up to CMS and we say "or" because it's not a big deal and for technical reasons one might be preferable or easier for them to do.

DR. ROWE: But where are you, Bob, on the interim question?

DR. REISCHAUER: I'm with David. I would hope that CMS

would move expeditiously on this matter and, therefore, it would go away.

DR. ROWE: If that were to happen, when would the change become effective?

MR. MULLER: What I heard Joe say about the DRG re-basing is about a year and-a-half lag.

DR. NEWHOUSE: Not the re-basing; the weights.

MR. MULLER: The re-weights. The DRG one is about --

DR. NEWHOUSE: I believe it's every year.

DR. REISCHAUER: I would presume if CMS can decide to drop blood out, it could decide to put it back in and this could be in next year's index.

MR. ASHBY: Just a quick point of clarification on the timing here. HCFA does process every five years, and I guess by the luck of the draw the fifth year is here. HCFA is committed to doing a -- reconstituting the marketbasket this very year. So the process is underway. The timing is really quite good.

DR. ROWE: When would it come into effect?

MR. GREENE: The year after.

MR. ASHBY: I believe it would come into effect about one year from today, October 1st of 2002.

DR. ROWE: So then the question is whether -- so now we've defined interim. It's one year. And the question is, what's the sense of -- whether there's sometihng to be done during that year, right? That was what was --

MR. ASHBY: Yes.

DR. ROWE: But now at least we know it's one year.

MR. ASHBY: But let me remind you also, we talked about reviewing the adequacy of base payment rate yesterday which we have not yet done here, and this sort of fits into that category. There's kind of an adjustment to where we are today, today really meaning a year from now because that's about as fast as the process works. We might want to think about it in that context, given all the other things that affect the rate for inpatient payments.

MR. HACKBARTH: Given the one-year duration of interim, and given that we've got automatic mechanisms in place. Given that logically if we make this exception we open the door to other similar claims and we have to go back logically and deduct it from the future, it seems like a lot of complexity and risk in terms of opening the door, to take for a one-year fix on a relatively small component in the overall cost structure.

I say that with sympathy to the institutions, but we've got mechanisms to fix this problem. This is just one example of something that can come up over and over again with various inputs.

DR. REISCHAUER: Would an add-on have to be a legislative change?

MR. GREENE: What we'd be saying would be, the Congress should consider it when it next legislates.

DR. REISCHAUER: Because I think realistically speaking, this probably wouldn't happen between now and January 1st, so it would be an after-the-fact repayment. I think it's just way too much trouble if we're urging that this be adopted within the next

year.

MR. HACKBARTH: I missed the first part. So your point is that the add-on would also take time, and wouldn't be immediate, so by that time the other mechanisms are in place; is that right?

DR. REISCHAUER: Yes. CMS has set the payment for next year.

DR. ROWE: One way to do it -- can I make an alternative suggestion? I'm just trying to think about it here. If we think that there's going to be an interim period where there is a modest disadvantage, particularly to those institutions concentrated in this, and we don't think there's an effective mechanism available to deal with it easily without all kinds of other problems, is it reasonable when the marketbasket change is made to take that into consideration in the amount of the change that is made, to sort of pay back or compensate it? Can that be done? Professor Newhouse is shaking his head no.

DR. REISCHAUER: I guess my question would be, why start with this year? Why don't we go back to the last 10 years, and then the sine might be different.

MR. SMITH: And wouldn't the consequence, the logical consequence of that argue that we ought to look at every modest that might have affected prices because of divergence from the marketbasket every year and then do a retrospective adjustment?

DR. NEWHOUSE: Plus it goes beyond price. If you have a new -- stents come in in the mid-'90s, they add on to the cost of doing angioplasty. It's a lag until that gets in to reimbursement and the hospitals just have to eat it.

MR. SMITH: I can't imagine, Jack, that if you took what you just recommended and abstracted it so we're about all inputs, that you'd support that kind of adjustment for --

DR. ROWE: I'm just trying to figure it out. I'm thinking about your spike argument. I'm thinking about other things that are spikes, like Y2K, this kind of thing. I remember when we used to add up pluses and minuses of things that we took into account. We said, that cost the hospitals X during that year so we added something. We did that. This group did that as I recall. So it's not as Alice-in-Wonderland as it might sound. But it sounds like it would not be feasible or appropriate to do with respect to this one thing, with respect to this one case. But that's how I got to --

MR. HACKBARTH: In the interest of allowing people to catch their planes, because as you'll recall from yesterday we have two items that need to be added on: the cancer hospital issue and a final decision on the consumer coalition issue. We need to squeeze those in this morning. We're not going to take a vote today. We had never planned to take a vote today on this issue. So it will be back before us next month.

What I'd suggest we do is set it aside for now, have the staff nail down some of the factual information around the timing issues so that we can be absolutely clear on how long interim is, as Jack puts it. Then we'll come back at our November meeting and actually have the final vote and decision on the issue. Are people amenable to that?

Floyd, if you have an issue that you would like the staff to

research during that period, go ahead.

DR. LOOP: I think that the dollar impact, that the DRG weights are something we should look at, and timing. So there are three things, unless somebody has some others.

MR. HACKBARTH: I'm sorry, I didn't hear the last part.

DR. LOOP: The timing of this if we put it in the marketbasket.

MR. HACKBARTH: Thanks, Tim.